

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/16/2013
NAME OF PROVIDER OR SUPPLIER MONROE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 15, and 16, 2013</p> <p>Facility number: 004016 Provider number: 004016 AIM number: N/A</p> <p>Survey team: Susan Worsham, RN-TC Cheryl Mabry, RN Diana McDonald, RN</p> <p>Census bed type: Residential: 47 Total: 47</p> <p>Census bed type: Other: 47 Total: 47</p> <p>Sample 08</p> <p>Monroe House was found to have been in compliance with 410 IAC 16.2 in regards to the State Residential Licensure Survey.</p> <p>Quality Review 05/17/13 by Lisa McColly.</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

TU0P11

If continuation sheet 1 of 1